

**CDC *Vital Signs* Town Hall Teleconference**

**Drinking and Driving in the U.S.  
Transcript**

October 11, 2011  
2:00pm – 3:00pm EST

Coordinator: Welcome and thank you for standing by. At this time all participants will be on a listen only mode until the question and answer session.

At the time of the question and answer session all lines will be open so please utilize your mute button. If you do not have a mute button at that time you may press star 6 to mute and unmute your phone.

Today's conference is being recorded. If you have any objections you may disconnect at this time.

I would like to turn the call over to Dr. Judy Monroe, Director of CDC Office for State Tribal and Territorial Support. Ma'am you may begin.

Dr. Judith Monroe: Well, thank you operator. Good afternoon everyone and welcome to this month's Vital Signs town hall teleconference. As the operator said, I'm Judy Monroe, I direct CDC's Office for State Tribal, Local and Territorial Support or OSTLTS's as we call it.

Today we're going to talk about a really important topic. Everyday almost 30 people in the United States die in motor vehicle crashes that involve alcohol impaired drivers. That's one death every 48 minutes and many of those deaths claim the lives of young people, our teenagers and young adults.

Additionally, one third of all traffic fatalities in 2009 involved a driver with an elevated blood alcohol concentration. Public support for this issue is strong and we're fortunate that we know what works to do reduce alcohol impaired driving and yet these strategies are under utilized.

This month's *Vital Signs* Report highlights the role that employers, health professionals, individuals and states can play in addressing this issue. Today we're going to hear from colleagues in New Mexico and Minnesota on how they have integrated many of the strategies identified in *Vital Signs* into their states comprehensive programs to reduce alcohol impaired driving.

One common theme for both programs is the importance of involving agencies and organizations from multiple sectors; law enforcement, public safety and health to have a meaningful impact and to save lives.

I also want to draw your attention to the National Prevention Strategy, another great resource that emphasizes this cross-sector integrated approach to prevent excessive alcohol use as part of its overarching goal to help American's live longer and healthier at every stage of life. So if you've not gone out and taken a look yet at the National Prevention Strategy, please do so. You can find that out on the Web.

It was developed and released this past spring by the National Prevention Council, the National Prevention Strategy recommends policies to reduce access. It identifies substance abuse early and providing people with necessary treatment and it recommends changing people's attitudes towards excessive alcohol use.

So, without further delay I'm going to turn the teleconference over to Kimberly Wilson from the Knowledge Management Branch here in OSTLTS

who will introduce our speakers and facilitate the discussion portion of today's meeting.

Kimberly Wilson: Good afternoon everybody. Thank you for joining us on our call today. Before we start with the presentations I'd like to remind you, you can download today's presentation and see the biographies for each of our presenters on our Web site.

The easiest way to get there is to go to <http://www.cdc.gov/ostlts/>. And that's O-S-T-L-T-S and then click twice on the town hall tab in the Flash module at the top of the page.

After the call today we're also going to add the recording and transcript of the call so that you can see them afterward and those should be available by the end of this week.

If you have any problems viewing the PowerPoint presentation right click on the link and click Save As to download it to your computer and this should eliminate any issues you have opening the big file in your browser.

Now, it is my pleasure to introduce our speakers today. I'm going to introduce all of the speakers now at the beginning and each one will hand off to the next.

Joining us today to provide a summary of this month's *Vital Signs* Report is Dr. Gwen Bergen a behavioral scientist with the Division of Unintentional Injury Prevention within CDC's National Center for Injury Prevention and Control.

Our next speaker will be Jim Roeber an alcohol epidemiologist with the New Mexico Department of Health. He will discuss how his state implemented a five-year program that combined traditional DWI law enforcement initiative with a programmatic component focused on reducing dangerous excessive drinking that ultimately saved lives.

Last we have scheduled to join us today, Mark Kinde the Director of the Injury and Violence Prevention Unit at the Minnesota Department of Health.

He has actually been delayed in joining us today but we hope that he'll be able to make it in time for his presentation as he's the last speaker. He's going to be discussing how Minnesota's efforts to reduce alcohol related injuries and death seem more visible and focused enforcement impaired driving education, community programs, stronger laws and multi-disciplinary partnerships.

And now I'm going to turn the call over to Dr. Bergen.

Dr. Gwen Bergen: Kimberly, thank you for that introduction. I'm going to summarize information from the *Vital Signs* that we released last week. Next slide, in 2010 four million adults reported at least one episode of alcohol impaired driving which resulted in an estimated total of approximately 112 million alcohol impaired driving episodes.

Although episodes of alcohol impaired driving has gone down by 30% since 2006, as Judy said, it remains a serious problem in the U.S. Alcohol impaired drivers, those who are at or above the illegal limit of 0.08 blood alcohol concentration are involved in about one in three crash deaths that resulted in nearly 11,000 deaths in 2009.

For this study the CDC used the data from the 2010 Behavioral Risk Factor Surveillance System Survey to provide estimates of the prevalence, episodes and rate of alcohol impaired driving among adults aged 18 years and older.

One question on alcohol impaired driving is asked periodically on the BRFSS Survey for each state. Respondents who report having had at least one alcoholic beverage in the past 30 days are asked, during the past 30 days, how many times have you driven when you've had perhaps too much to drink?

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We found that certain groups were at more risk than others. Men were responsible for 81% of the alcohol impaired driving episodes in 2010 and young men ages 21 to 34 were responsible for 32% of all instances.

Eighty-five percent of alcohol impaired driving episodes were reported by persons who also reported binge drinking. Binge drinking means five or more drinks for men or four or more drinks for women during a short period of time. And what was especially interesting that the 4.5% of the adult population who reported binge drinking at least four times per month accounted for 55% of all alcohol impaired driving episodes.

Next slide.

The 112 million episodes of alcohol impaired driving reported in 2010 was the lowest number of episodes reported since 1993 which is the first year that published national BRFSS estimates were available. Since the peak in 2006, alcohol impaired driving episodes have declined 30% from 161 million to 112 million.

During this time alcohol impaired driving fatalities also declined by 20% from 13,491 fatalities in 2006 to 10,839 fatalities in 2009. And 2009 is the most recent year for which we have fatality data available.

However, the proportion of all motor vehicle fatalities that involve at least one alcohol impaired driver has remained stable at about 33%. We don't understand the reasons for the decline in alcohol impaired driving but possible factors include less discretionary driving because of the current economic downturn and possible changes in drinking location to places where driving is not required such as at home.

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This map shows the rates of drinking and driving episodes among adults by state and we've found that the Midwest census region had the highest annual rate of alcohol impaired driving episodes at 643 episodes per 1000 population. This rate was significantly higher than the rates in all other regions.

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The good news is that there are effective strategies to reduce alcohol impaired driving but they are under utilized in the United States. Policies such as enforcement of the 0.08 blood alcohol concentration laws and minimum legal drinking age laws, sobriety check points and ignition interlock programs for all convicted alcohol impaired driving offenders can reduce alcohol impaired driving.

Given the strong association between binge drinking and alcohol impaired driving that this study found, programs to reduce alcohol impaired driving should consider adding effective strategies to reduce excessive drinking.

These strategies include increasing alcohol taxes, regulating the density of alcohol outlets and dram shop liability laws.

These laws hold alcohol retailers legally responsible for harms caused by illegal beverage service including serving to minors and to visibly intoxicated patrons.

Public support for preventing alcohol impaired driving is strong. Seventy-five percent of respondents in a recent survey endorsed weekly or monthly sobriety check points. Public support for ignition interlock programs is also strong. In another survey 90% of respondents supported requiring ignition interlocks for drivers with multiple alcohol impaired driving convictions and 69% supported requiring interlocks for drivers upon their first conviction.

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Seatbelts play an important role also and another interesting finding in the study was related to seatbelt use. Person's who reported not always using seatbelts had alcohol impaired driving rates nearly four times higher than persons who reported always using seatbelts.

Among respondents who reported driving while impaired, 76% of persons living in states with a primary seatbelt law reported always wearing a seatbelt whereas 58% of their counterparts living in states with no seatbelt law or a secondary law reported always wearing a seatbelt.

Primary laws allow police to stop drivers and ticket them solely because occupants are unbelted while secondary laws only allow police to issue seatbelt tickets if drivers were stopped for some other violation. And CDC

recommends primary enforcement seatbelt laws covering all positions of the vehicle.

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In closing, I want to briefly point you to a few CDC resources on alcohol impaired driving. The community guide is a free resource to help you choose programs and policies to improve health and prevent disease in your community. The guide has reviewed 12 interventions to reduce alcohol impaired driving, eight of these have been recommended as effective. These include the 0.08 blood alcohol concentration laws, lower blood alcohol concentration laws for younger drivers, minimum legal drinking age laws, sobriety checkpoints, mass media campaigns, school-based instructional programs and finally multi-component interventions with community mobilization which can include a number of components such as sobriety checkpoints, training and responsible beverage service and limiting access to alcohol.

The second resource is the Policy Impact. The Policy Impact is a series of briefs highlight key public health issues and highlighting the (science-based) policy actions that can be taken to address them.

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In closing, I'd just like to emphasize that drunk driving is never okay. Choose not to drink and drive and help others do the same.

And, at this point, I'd like to turn it over to Jim Roeber from New Mexico.

Jim Roeber: Okay, good afternoon folks. Next slide please?



So, my name is Jim Roeber. I'm the CDC Funded Alcohol Epidemiologist for the New Mexico Department of Health.

Today I will talk about the recent impact or the impact of a recent comprehensive prevention program to reduce alcohol impaired driving and driving while intoxicated in New Mexico. Thanks for this opportunity to share our recent experience.

Next slide please?

So this slide describes New Mexico's comprehensive DWI Prevention Program. In 2005 New Mexico undertook a five-year comprehensive multi-agency program to reduce dangerous excessive drinking, driving while intoxicated or DWI and ultimately alcohol related motor vehicle crash deaths.

This program was led by cabinet level DWI's and advised by a multi-agency DWI leadership team that included numerous state agencies including the Department of Public Safety, the Department of Transportation, etc.

The National Highway Traffic Safety Administration, NHTSA, funded the program as a national demonstration project at a level at about \$1 to \$2 million per year. The program used a well-established prevention model based on the work of Harold Holder and others using strategies recommended by the Community Guide, the World Health Organization and the Institute of Medicine.

And the program focused on the six New Mexico counties with the highest numbers and/or rates of alcohol related motor vehicle crash deaths comprising

about 50 to 60% of the total alcohol related motor vehicle crash deaths in the state.

Next slide please?

This slide shows the DWI Prevention Programs logic model, an important aspect of New Mexico's DWI Prevention Program was that it combined traditional DWI law enforcement initiatives with a programmatic component focused on reducing dangerous excessive drinking particularly high intensity binge drinking in bars and clubs of the kind the precedes many DWI events.

The components of the DWI Prevention Program that focused on reducing excessive drinking are shown in blue on the slide. These included first strengthening the liquor control regulations that prohibit illegal sales and services to minors and intoxicated persons and specifically reducing from five violations to three violations the number of violations for illegal sales and service that were required before a licensee was subject to license revocation.

And then the second component of this was actually increasing liquor control law enforcement. This enforcement of liquor control laws was intended to increase the perception of risk of citation among liquor licensees and encourage better compliance with liquor control regulations and more responsible alcoholic beverage service to reduce illegal sales and service to intoxicated persons in particular and ultimately to reduce dangerous binge drinking particularly binge drinking and license premise such as bars and clubs where many DWI events originate.

The illegal sales and service regulation was successfully strengthened in 2006 and increases in liquor control law enforcement followed soon thereafter. New Mexico is one of the few, if not the only state, that has a per sale limit for

intoxication, sale of alcohol to a person who has been shown to have a blood alcohol content of 0.14 or higher is the basis for a sales to intoxicated person liquor control violation which is issued to the liquor licensee.

So called sales to intox violations increased almost four-fold following the regulation change relative to earlier periods as a result of increased liquor control law enforcement and this law enforcement created a number of cases for license revocation that led to the first liquor control license, I'm sorry, the first liquor license revocations in New Mexico history. And all of this was perceived to dramatically increase the perception of risk of negative consequences for illegal sales and service among liquor licensees.

The second component of the program, the component of the programs logic model that focused on reducing impaired driving is shown in yellow in this slide. This component was based on a model that has been shown to be effective in reducing DWI and its consequences.

This model involves increased DWI law enforcement particularly in the form of sobriety check points coupled with a public awareness campaign in the form of both paid and earned media which, together, act to increase the perception of risk of DWI arrest.

This increased perception of risk leads individuals to reduce their drinking and driving behavior thereby reducing alcohol impaired driving and its negative consequences. Roughly \$3 million was spent on increased DWI law enforcement over the five-year program period and roughly \$2 million was spent on the public awareness campaign.

Regularly scheduled, these DWI super blitz period, so called, these are periods of increased sobriety check points coupled with increased supporting media activity where the cornerstone of this DWI law enforcement effort.

So now I will talk about the impact of New Mexico's DWI Prevention Program on both the risk behaviors that proceed DWI, binge drinking and alcohol impaired driving and on the ultimate consequence of alcohol impaired driving, alcohol related motor vehicle crash fatality.

Next slide please?

So this slide shows changes in DWI related risk behaviors associated with this prevention program. The Behavioral Risk Factor Surveillance Survey, BRFSS, a random digit dialed land-line telephone survey of adults aged 18 and over which provides annual estimates of the prevalence of risk behaviors in the New Mexico adult population provided a valuable resource for assessing these changes.

The BRFSS includes a core binge drinking question which has allowed us to assess changes in binge drinking prevalence and frequency over the program period. Binge drinking, of course, is a high risk excessive drinking behavior that is defined, for males, as drinking five or more drinks on an occasion and for females as drinking four or more drinks on an occasion.

The New Mexico BRFSS also included a special binge drinking module during the years 2004, 2005 so years prior to the program and then again in 2007 and 2008, years sort of in the middle of our program.

This module allowed us to look at changes over the program period in binge drinking intensity, the number of drinks per binge drinking episode, binge

drinking location and driving after binge drinking which we used as a measure of alcohol impaired driving.

So looking first at binge drinking on the left-hand side of the slide, comparing rates for 2004, 2005 to 2007, 2008; no reductions in binge drinking prevalence or frequency were seen associated with the program. However, substantial reductions in binge drinking intensity, the number of drinks on the last binge occasion were seen and are suggestive of a program impact.

Binge drinkers in bars and clubs reported a 16% decrease in binge intensity which is perhaps suggestive of better compliance with over service regulations among licensees, liquor licensees.

And binge drinkers who reported driving after binge drinking reported a 19%, almost a two-drink decrease in binge intensity from 9.2 drinks to 7.4 drinks on the last binge occasion. Perhaps this is suggestive of reductions in high-risk drinking behavior among these drinkers in response to an increased perceived risk of DWI arrests.

The BRFSS also showed a significant 27% decrease in the prevalence of binge drinking in licensed premises; bars, clubs, restaurants, etc. Males in particular reported a significant 35% decrease in drinking and license premises reflecting a reduction in the prevalence of binge drinking bars and clubs and an increase in binge drinking at home.

These changes in binge drinking behavior suggest that a comprehensive DWI Prevention Program that includes measures to reduce excessive consumption as well as DWI may meaningfully reduce dangerous excessive drinking, for example, high intensity binge drinking, at the population level.

Looking next at changes in alcohol impaired driving on the right-hand side of the slide, again, comparing rates for 2004, 2005 to 2007 and 2008, a large 33% and statistically significant reduction was seen in the prevalence of driving after binge drinking during the program period.

The reduction in so-called binge driving was particularly apparent among males who showed a 36% reduction. This reduction in driving after binge drinking was driven by a large 41% decrease in binge driving among binge drinkers who drank in residential settings. There was essentially no decrease in the binge driving rate among binge drinkers who drank in bars.

Roughly one in five binge drinkers who reported binge drinking in bars and clubs also reported driving after binge drinking both before and during the program period. However, because fewer binge drinkers, particularly male binge drinkers, were drinking in bars and clubs, the monthly number of binge drinking and binge driving episodes that originated from bars and clubs actually decreased substantially during the program period.

The reduces seen in binge intensity and the number of binge drinking and driving episodes originating in high risk settings of bars and clubs and the 33% reduction in driving after binge drinking all speak to the potential value an effectiveness of program elements directed at reducing excessive consumption.

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Of course the ultimate measure of the effectiveness of a DWI Prevention Program is its impact on alcohol related motor vehicle crash fatalities. In that regard from 2005 to 2008 New Mexico's alcohol impaired motor vehicle

crash fatality rate decreased 39% as shown on this slide and New Mexico's rank dropped from 6 to 26 in the nation.

In other words, after almost a decade of flat rates New Mexico was able to once again achieve substantial decreases in DWI and related outcomes using a comprehensive prevention program that focused on reducing not only DWI itself but also the excessive drinking behavior that precedes it.

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So, in conclusion, hopefully these results suggest that a comprehensive evidenced-based DWI Prevention Program that addresses both excessive consumption and alcohol impaired driving can be associated with population level reductions and DWI related risk behaviors such as high intensity binge drinking, binge drinking in bars and clubs and binge driving. And also with reductions in DWI related outcomes in particular alcohol impaired motor vehicle crash fatality rates.

And then another conclusion that we took from this experience was that the BRFSS binge drinking module is a really useful tool for the surveillance of DWI related behaviors and can really help assist in the evaluation of DWI Prevention Programs.

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So I'd just like to make a few acknowledgements. Of course, New Mexico's five-year DWI Prevention Program involved extensive collaboration among many state and local agencies but I'd like to especially acknowledge Rachel O'Connor who is the DWI who led the successful effort and Mike Sandoval

of the New Mexico Department of Transportation who administered much of the work.

I'd also like to acknowledge Vivian Heye and Wayne Honey in the New Mexico Department of Health Survey Section for their great work in administering and managing the New Mexico BRFSS data that informed this analysis.

And finally, last but certainly not least, I'd like to acknowledge Bob Brewer and the CDC Alcohol Program whose ongoing support of alcohol epidemiology capacity in New Mexico helped make this analysis possible.

Thanks very much.

And now I will turn this over to Mark Kinde, hopefully he's on the phone.

Mark Kinde: He is indeed and thanks colleagues. This is Mark from Minnesota from the Minnesota Department of Health and it's great to be joining the folks across the nation today to talk about what's happened in Minnesota with reducing alcohol related crashes and deaths.

My colleagues who are really anchoring today's presentation are my colleagues from our Department of Public Safety, our Office of Traffic Safety, Jean Ryan is our Impaired Driving Program Coordinator and Lieutenant Colonel Matt Langer with Minnesota State Patrol. And they're going to highlight some of the key aspects that really has been the foundation of the success that (folks) are very thankful in Minnesota.

And, together, our agencies are part of the Towards Zero Death partnership. We also have our Minnesota Department of Transportation. They were not



able to join us at the table today but they're a key anchor in looking at how best to partner together to reduce injury and death associated with motor vehicle crashes in Minnesota.

In our Towards Zero Death partnership we focus on engineering issues, education, enforcement and then our emergency medical and trauma services. Our - you should be on the slide from our Commission of Health, Dr. Ed Ehlinger.

Ed has said that public health is a constant redefining of what is unacceptable. And as we work together we partner to say in Minnesota alcohol related crashes and deaths are not acceptable. And we've committed ourselves to partner in this in pushing for culture change to try to make a difference. I think my colleague, Jim, in New Mexico has nicely used the reference to the BRFSS data from their state and some of the comprehensive programs, the partnership with (NITSA) and using referenced programs and efforts that are demonstrated to make a difference.

And what my colleagues will share here is Jean and Lieutenant Colonel Matt Langer speak, are what we've done on the ground to make a difference. Jean has got some compelling data from Minnesota and we're really excited to do that. And I'll join in at the very tail end to talk about some of what our role in the Health Department is as well.

Jean?

Jean Ryan:

Hi. Next slide?

One thing that's always key to an effective program is data. The programs need to be data driven and targeted towards programs that will be effective in reducing alcohol impaired driving.

Without data of doing data analysis to determine where and when the problem occurs and then evaluating the success of that program as well, we really can't be effective in reducing those fatal crashes.

The other thing that's key to any good program is partnership. We certainly have tried to tear down those silos and work with our other departments as Mark had indicated, working with public health and working with our law enforcement and working with our engineer and working with our emergency services. And we can't forget those judicial partners as well in trying to figure out how we can partner together to be effective in our programs.

But, bear in mind there really is no silver bullet, you know, we were kidding a little bit when we created the slide but it is an arrow but there is no silver, it looks like silver as well, bullet. It is a conglomeration of different effective programs that really will make a difference in reducing those fatalities.

Next slide?

Mark addressed a little bit about our Towards Zero Death Program. We're very proud and we feel very committed to our Towards Zero Death Programs and building that partnership with all of our stakeholders as well as our community stakeholders. And Lieutenant Colonel Langer is going to speak a little bit about the enforcement programs that we think are key to reducing that impaired driving fatality.

Matt Langer: Right, when we were commenting in contrast to New Mexico, we don't have the ability to do checkpoints in Minnesota. So our tactics are quite a bit different and, at times, to be honest politically right now we're challenged even with the term saturation. But we proceed forward and we've been very successful kind of trying to combine the elements of a checkpoint and the elements of a saturation to basically get the message out to the public that we're coming to enforce the DWI law.

If we catch you, you'll go to jail but our preference would be that you would choose a better way and that you get a sober ride home or call a cab or obviously to prevent this from happening in the first place.

So we do a couple of different things and we have our high visibility saturations. It's been sort of now rooted in culture for our agency especially in the metropolitan area on Minneapolis and St. Paul that we use roadway signs and that's a partner between the Department of Transportation when we can or with private contractors to get freeway signs out, just giving messages like DWI saturation, don't drink and drive, buckle up, etc.

And then we use selected roadways and time of day because we can't do checkpoints we try to highlight our enforcement areas in certain corridors to have a lot of effectiveness and to also have a lot of visibility so that the public kind of turns their head and looks and then maybe in a perfect world sees a sign and sees someone getting pulled over and realizes that stuff I heard on the radio yesterday is in action tonight. And when I go out and drink I will choose a better ride home. So that's maybe connecting a few more dots than everybody connects but that's our goal.

And then the next piece I'll talk about is related to media. We really worked hard to target our messaging at the right group of people. I don't think we

have that down to a science. I don't think anybody does. I don't think we have the perfect solution but we really worked hard to get our messages out to the people that we can impact the most and that is that age group of 21 to 34 year olds, predominantly male.

And I'll turn it back to Jean for the rest here.

Jean Ryan: Well, the other thing that's key and what we realize is that you can't just go out there and do impaired driving enforcement without getting the community in support of that enforcement as well. Without that community support there's a lot of pushback from the city council, county boards, different people within the community that don't particularly appreciate that enforcement effort.

So we tried to build that community support and build community programs such as safe ride programs within that community that offers alternative rides so if the person does go out and decides that they are planning on going out and drinking that there is a safe ride home to make sure that they do not drive impaired.

Media events that actually tell people we want - the key is that they need to know that the enforcement activity is occurring. We don't want any surprises. We want them to realize what's going on and hopefully like Lieutenant Langer said, they just make a different decision.

But the other thing that's key and the speaker before us talked a little bit about stronger laws, as far back as anybody can remember, swift and certain sanctions are key to changing behavior and that includes drinking and driving behavior.

Severity plays a role but we know that swift and certain is actually even the two that are most effective in changing that behavior. And what we have just pass recently a law that will require ignition interlock on the car of those arrested at twice the legal limit, 0.16, first time offenders, 0.16, and above and all repeat offenders.

So if you're driving and you are a first offender over 0.16 or a repeat DWI offender, seven days after you're arrested if you want to drive you're going to have to install ignition interlock on your car.

So that is - we are hoping to find additional achievements from a result of that particular law but Minnesota has had, and we've worked very hard on developing strong laws that are effective in reducing impaired driving.

The other thing that's the multi-disciplinary partnerships and the culture changes, you know, they kind of all roll in together, I would say. You know, in order to create culture change it takes a lot of partnerships working in tandem and what we are hoping through our different programs, working through our community coalitions and our impaired driving enforcement activities and such is creating a culture change that people, you know, it's kind of like a smoking culture change that if people decide that it's no longer an acceptable thing to do, to get in the car and drive impaired.

We've come a long way with impaired driving but we still have a ways to go and we continue to work on developing that culture change in Minnesota.

Mark Kinde: Part of this, Jean and Matt, thanks a lot, is helping people tell their story. It's developing the narrative that combines the public health and education and enforcement scenarios into a story, a narrative, for our communities that helps folks understand the impact that my driving impaired, my driving drunk, is not

just about me. It makes a difference to the community in which I'm living and working, the community in which I'm traveling and makes a tremendous impact in another families life whose vehicle I hit or whose children I hit crossing the street.

The data that we've used, and I'll just speak for a few seconds before we look at some of the data in Minnesota that Jean has for us, but we developed the Minnesota Injury Data Access System. You'll find the Web link there under (MIDAS) and instead of just focusing on national level or even all state level data, we found that if communities can look at their county or their large city and look at the injury and death data as it pertains to motor vehicle crash in this instance that they can help tell that story to their county commissioners, to their legislators and that's contributing to the culture change.

Finally, our emergency medical and trauma services is part of that kind of catchment we'd prefer not having the excellent trauma services that we have but thankful that we do have them.

But we wish that - I mean, our goal in this culture change is to try to not have to utilize their expertise in the triage transfer and transport in Minnesota.

Jean Ryan: Next slide?

The thing that - if you look at Minnesota's data this is a little...This is a graph showing what Minnesota's alcohol related fatalities over the past - since 2001 to 2010. And you can see from 2003 to 2010 we did experience a 59% reduction. However, I'd like to look a little bit further down where you look in 2008 and that was the absolute historic low that Minnesota experience with alcohol related fatalities since we started collecting the data.

And since 2008 to 2010 we still have had a 20% reduction in those fatalities and what I'd like to do is dig a little bit deeper in determining and taking a look at who were those people that actually we had an affect in reducing that number.

Mark Kinde: Next slide.

Jean Ryan: Next slide, excuse me. Next slide.

From 2008 to 2010 the highest reduction occurred in the age groups from 20 to 34 year olds. So that's why we're kind of a little bit excited about here because what we know about it is that that is the part in the age group that we've been targeting for quite some time is that 20 to 34 year olds. And when you look at some 72 to 41, that reduction that occurred in that time period obviously where we're within that 20 to 34 year old age group with the 43% reduction.

So that's kind of hopefully it's not a science yet because it's only a two-year time period but it is a trend that we hope that continues and we hope to continue to achieve that type of success in that age group.

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This is - I just want to quickly pass by this slide but you can see on the time periods where there was no significant change and if you take those out of the picture, look at the next slide. You can look at the time of days where we've had the most significant affect in reducing those impaired driving fatal crashes as well.

And we, for a long time, have been focusing on that - I think every state focuses on late time, late night driving, for impaired driving fatalities from about 9:00 in the evening until 3:00 and sometimes even later in the evening.

And you can see in the last two years we've had a 50% reduction in alcohol impaired fatal crashes. These are drinking drivers that were involved in an impaired driving fatal crash and those particular crashes were reduced by 50% which is great because that is the time of day, also, our programs have been focusing on which we have, until now, begs the question is when you look at the 6:00 to 9:00 they've actually increased a bit.

So, yes, we probably should start adjusting our programs a little bit and not ignoring those early evening impaired driving fatal crashes as well.

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Just to sort of recap of Minnesota's data, we've been down since 2008 comparing 2008 to 2010 we're down 20% in deaths, alcohol impaired driving deaths. Hospital treated injuries, 14%, alcohol related crashes down 12%. We continued to see about a 50/50 split between urban and rural disparity and so I misspoke one thing up on the top, as deaths are alcohol related, not alcohol impaired. Those include the under 0.08 data but in Minnesota those are not actually - there's not a lot of them.

So, next slide?

Thank you. Here's our contact information if you'd like to have additional questions. You can certainly call us or email us.